**H3132 AHF MCO of Florida, Inc.**
**Chronic or Disabling Condition (HIV/AIDS) Special Needs Plan**

**Model of Care Score: 98.33 %**
**3-Year Approval** **January 1, 2015 – December 31, 2017**

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## Target Population

Positive Healthcare Partners Florida (PHP-FL) also known as AHF MCO of FL, is a chronic care special needs plan targeting qualified Medicare members who have a diagnosis of HIV and reside in the Broward and Dade counties in Florida; members have Medicare Part A, Part B and Part D eligibility and/or are full benefit dual-eligible Medicare and Medicaid members. PHP-FL is expanding to Duval County to address the high incidence of HIV. The majority of PHF-FL's target population is male (85 percent) and 56 percent of members are between the ages of 45 and 64 years. While there are members of Asian Pacific Islander, Native American and other ethnicities, the highest percentage of members are non-Hispanic White, with African Americans the second largest percentage of members.

The three most important factors for length and quality of life for people living with HIV/AIDS (PLWHA) are access to HIV experienced primary care physicians (PCP), adherence to antiretroviral medication therapy and a system of care to keep PLWHA engaged in their care. HIV/AIDS members tend to have higher mortality rates, multiple complex medical conditions, behavioral health issues, substance abuse and depression.

## Provider Network

PHP-FL provides specialized HIV chronic disease management focusing on care management, consumer empowerment, self-management, home safety, safer sexual practices, and prevention for positives (HIV) and transitions of care. The provider network consists of primary care physicians (PCP), specialists such as cardiology, oncology, endocrinology, ophthalmology, neurology and dermatology, acute care facilities for inpatient and ambulatory care, long-term care, skilled nursing facilities, free standing acute rehabilitation hospitals, acute psychologist, ancillary and support services such as lab, pharmacists, physical, occupational and speech therapist, dental services, home health and hospice care and 24-hour nurse advise line. The PHP-FL primary care network is comprised of AHF staff primary care providers and network providers with specialized HIV training.

## Care Management and Coordination

The health risk assessment (HRA) is completed within 90 days of enrollment and at least annually thereafter and upon significant change in the member's health status. The assessment is

conducted telephonically, however, a home visit assessment may be performed. The Registered Nurse Care Team Manager (RNCTM) obtains additional input into the HRA from the member's HIV PCP. The HRA collects information such as demographic data, employment, living environment, social services, ancillary health services, benefits, mental health and life habits information, current therapy and/or medications, exercise, diet and nutrition, and activities of daily living, medical history, AIDS case definition categories (asymptomatic, symptomatic, AIDS indicator condition), antiretroviral drug therapy history by drug category, investigational drug history, pain history, sexually transmitted diseases, prosthesis and/or implanted devices and laboratory results. This initial information informs the care planning process and the development of the individualized care plan (ICP) and is shared with the interdisciplinary care team (ICT).

The ICT consists of the member or caregiver, the member's HIV PCP and the RNCTM. Other ICT members are added based upon the individual needs and could be a pharmacist, behavioral health professional, license practical nurse, care coordinators, medical social worker and a utilization management nurse. The ICT meets on a routine monthly basis, with a concerted effort to meet on a personal face to face basis. When circumstances dictate, conference calls are made with web support. The ICT conducts a comprehensive review of health trends of patients and overall clinical performance, based on the measurable goals. The ICT tracks and trends aggregate data collected from the HRA, medical record review and the medical and pharmacy claims system to identify opportunities to add specialized benefits, services or more refined interventions.

As previously stated, the RNCTM analyzes the HRA and collaborates with the ICT and PCP to create an ICP which is tailored to the member's needs and preferences. The ICP contains essential components such as identification of the problem/concern, goals or objectives that are specific, measureable, achievable/accurate, and realistic and within a timeframe; a process called SMART. In addition, they perform specific interventions to achieve goals, tracking progress of the goals and continual evaluation to determine if goals are still achievable and strategize to follow-up on those goals. The ICP directs the improvement of the member's health status and quality of life. A copy of the ICP is available to the member, their caregiver/support system if appropriate, the ICT and PCP.

This MOC summary is intended to provide a broad overview of the SNP's MOC. Although the full extent of any MOC cannot be conveyed in a short summary, this summary provides the reader with a general overview of how the SNP addresses beneficiary needs.

For more information about this health plan refer to the Special Needs Plan's website at: http://positivehealthcare.net/florida/php/